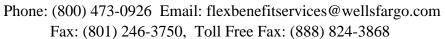


WELLS FARGO FLEX BENEFIT SERVICES

381 East Broadway #110, Salt Lake City, UT 84111

Website: www.wffbs.com





Employee Claim Form REQUEST FOR REIMBURSEMENT

Company Name			Employee	Social Security Number		
Employee Last Name	First Name	M.I.	Daytime To	elephone Number		
Employee Street Address			City, State	, Zip		
Address Change						
W.F.F.B.S. policy req	quires that this form be filled out	completely (see form instructi	ons). Incompl	ete and undocumented claims	will not be processed.	
	Health	Care Reimburse	ement A	ccount		
Date Expense Incurred	Patient Name	Name of Service Provider Expense De		Expense Description	Amount	
Month Day Year					s	
					\$,	
					\$,	
					\$,	
					\$	
					\$	
Additional Clair	m Forms are attached.			TOTAL	\$,	
	_	are Reimburser				
Date Expense Incurred Month Day Year	Name of Service F	Provider	Tax ID #	# / Social Security #	Amount	
FROM						
то					\$ <u> </u>	
FROM						
TO					\$	
Additional Clai	m Forms are attached.			TOTAL	\$, <u></u>	
expenses during the plar In addition, the tot (Special maxi	nt for the expenses listed ab n year and during a period wexpenses un al amount claimed for day imums and conditions may nnot claim these same expe	while the undersigned wa der our insurance plan or care does not exceed the apply if your spouse is a	s covered up under any of lesser of my student or i	nder this plan. I have not other source. or my spouse's expected as handicapped and has no	been reimbursed for these income for the year. other income.)	
Employee Signature				Date Submitted		

Instructions:

- 1. Complete the Employee Information Section.
- 2. Complete the Health Care section and/or Day Care section as appropriate. If all entries will not fit on one form, complete and submit an additional form(s) as necessary.
- 3. Attach supporting documentation as described below.
 - A. **Explanation of Benefits From (EOB):** This is the form you receive each time you or a health care provider submits claims for payment to your medical, dental, or other health care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) medical, dental, or other health care plans, you **must** attach an EOB.
 - B. **All Other Health Care Expenses:** For expenses not covered at all by your (or your spouse's) medical, dental, or other health care plans, reimbursement requests **will not be processed** without acceptable evidence of your expenses. Acceptable evidence includes itemized statements that contain the following information:
 - 1) Actual date(s) expense was incurred*
 - 2) Name of person for whom the service/supply was provided
 - 3) Person or organization providing the service/supply
 - 4) Description of service or supply
 - 5) Cost (Note: taxes are not a reimbursable expense.)
 - C. **Day Care Expenses:** Please attach a receipt, (or a signed, itemized statement), that includes:
 - 1) Actual date (From and To) of service*
 - 2) Name, address, and Tax ID or SSN of the provider
 - 3) Cost
 - 4) Dependent(s) name who received the care.
 - * Only expenses incurred during the current year are eligible for reimbursement.
- 4. **Sign** and date the form.
- 5. Mail, Fax, or Email the completed, signed form and attachments to the address, fax number, or email address on the front of the form. An incomplete form, missing signature or missing attachments may result in delayed processing or claim denial.
- 6. If you have questions regarding your reimbursement account or claims, please call customer service at 1-800-473-0926.